Nova Scotia
Advisory Council on
the Status of Women

REPORT ON
THE STATUS OF FAMILY PLANNING
AND SEXUALITY EDUCATION
IN NOVA SCOTIA

SUBMITTED TO
THE HONOURABLE DAVID NANTES
MINISTER OF HEALTH AND FITNESS

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PREFACE

The Nova Scotia Advisory Council on the Status of Women was established in 1977 to monitor women's issues and to act as an advisory body to the provincial government. Specifically, the Council is legislated to:

-- advise the Minister upon such matters relating to the status of women as are referred to the Council for consideration by the Minister responsible for the Administration of the Status of Women Act;

-- bring to the attention of the Minister matters of interest and concern to women.

In carrying out its duties, the Council may:

-- receive and hear petitions and suggestions concerning the status of women;

-- undertake and recommend research on matters relevant to the status of women;

-- recommend and participate in programs concerning the status of women;

-- propose legislation, policies and practices to promote equality of opportunity and status;

-- publish reports, studies and recommendations.

INTRODUCTION

Fifty-seven percent of grade 11 students in Nova Scotia have had sexual intercourse -- about half of them engage in sexual intercourse regularly, and 59 percent of those sexually active have had two or more sexual partners. Thirty-two percent of grade 9 students in the province have had sexual intercourse at least once; 65 percent have engaged in sexual activity that included petting below the waist.[1] Less than 20 percent of sexually active college students report using condoms; the percentage is undoubtedly lower for high school students.[2] Approximately 1 teenage girl in 16 becomes pregnant in this province each year. In 1986, 479 girls 19 years of age and under obtained therapeutic abortions. In the same year, Nova Scotia had the sixth highest provincial teenage pregnancy rate.[3]

Regardless of whether or not we are willing to acknowledge it, and regardless of whether we think it morally right or wrong, greater numbers of teenagers are engaging in sexual activity at younger and younger ages.

It is not within the scope of this report to examine in detail the possible reasons for this trend toward earlier sexual activity; however, it is clear that we have an urgent responsibility to take action against the often unintended repercussions of such activity. As Orton and Rosenblatt note in their assessment of adolescent pregnancy prevention programs in Ontario, "adolescent pregnancy trends must be viewed within the context of ongoing broad social changes: extending education, declining adolescent marriage, [and] changing patterns of

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[1] Canada Youth and AIDS Study, Nova Scotia Report, p. 23-24.

[2] Forty-five percent of grade 11 students in Nova Scotia reported they would be embarrassed to buy condoms. Canada Youth and AIDS Study, Nova Scotia Report, p. 21.

[3] Planned Parenthood Nova Scotia, "Five Ways to Prevent Abortion", Halifax Chronicle-Herald, Nov. 11, 1989.

pregnancy and fertility amongst all women..."[4] We must also look to the myriad of media images of sexuality and sexual permissiveness as having some influence on our attitudes and behaviour. But "although Canadians continue to be presented with media images and social expectations which encourage early sexual involvement and risk-taking, they are unlikely to receive adequate information and guidance concerning responsible, well-informed sexual decisions."[5]

In light of the rising number of teenagers who are sexually active, the rising levels of sexually transmitted diseases (STDs), and the current abortion debate in this province, it is imperative that the government of Nova Scotia begin to implement preventative measures to protect teens and adults from unwanted pregnancies and STDs. Preventative measures are required at all levels; not state control and regulation. Educational programs are needed to increase the informed choice of individual Nova Scotians to engage in, or to refrain from, safe sexual activity. The Report of the National Consultation on Research Needs in Sexuality and Reproductive Health states that "the consequences of failing to promote healthy sexuality from birth throughout life will be seen in high rates of sexually transmitted diseases and unwanted pregnancy."[6] We are now seeing the consequences of that failure in Nova Scotia.

Contrary to the assertions of the anti-choice movement,[7] an evaluation of an adolescent pregnancy prevention program implemented in Ontario in 1975 concludes "that public preventitive programmes of sexuality education in schools and family planning services in public health units, have not caused adolescent pregnancy rates to rise. Access to abortion services has not increased sexual irresponsibility and caused adolescent pregnancy rates to rise."[8] The Alliance

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[4] Orton and Rosenblatt, Adolescent Pregnancy in Ontario: Progress in Prevention, p. 4

[5] Planned Parenthood Federation of Canada, Directions for a Sexual and Reproductive Health Policy for Canada, p. 7

[6] Calgary Health Services, Report of the National Consultation on Research Needs in Sexuality and Reproductive Health: A Public Health Perspective, p. 39

[7] Nova Scotians United for Life, "Planned Parenthood: Illusion vs. Reality".

[8] Orton and Rosenblatt, Executive Summary, Adolescent Pregnancy in Ontario: Progress in Prevention, p. 3

For Life mistakenly argues that increases in the level of teenage sexual activity, the premarital pregnancy rate, the abortion rate, and the incidence of venereal disease are the result of the provision of prevention services. Actually, increasing family planning and sexuality education and services is merely a urgently needed response to increasing levels of sexual activity among all age groups, particularly teenagers, which results in higher rates of unintended pregnancy and sexually transmitted diseases.

The International Conference on Population held in Mexico City in 1984 adopted the following recommendation for action: "Governments are urged to ensure that adolescents, both boys and girls, receive adequate education, including family life and sex education, with due consideration given to the role, rights and obligations of parents and changing individual and cultural values. Suitable family planning information and services should be made available to adolescents within the changing socio-cultural framework of each country."[9]

The Nova Scotia Advisory Council on the Status of Women does not take issue with those parents who feel that the sexuality education of their children and teenagers belongs in the home. Certainly, this can be one of the very best places for young people to get information and discuss controversial topics in an atmosphere of support and safety. To suggest, however, that home education is sufficient is clearly refuted by the fact that in Nova Scotia in 1987 there were 947 births to teenagers and, in addition, teenagers obtained approximately 200 therapeutic abortions.[10] For these teenagers, and many others who escaped pregnancy or infection only through "luck", home education was not enough.

Unfortunately, many parents do not provide any sexuality education for their children, either because they feel uncomfortable discussing it or because they themselves do not have the necessary factual and current information to pass on. Some parents refuse to discuss safe sex practices because they feel that such information would encourage their children to participate in sexual activity knowing they were "protected" or would appear to give them parental

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[9] Roemer, "Legislation on Abortion and Contraception for Adolescents", p. 241.

[10] Statistics Canada.

permission to do so. According to a 1984 Gallup Poll, only one in five adults received any sex education at home and 64 percent would have liked more information.[11] Only 29 percent of grade sevens, 13 percent of grade nines, and 11 percent of grade elevens cited family as their main source of information about STDs.[12] Clearly, few teenagers feel that they can talk to their parents about sexual health matters, and few parents are adequately prepared to deal with their children's difficult questions.

According to the Planned Parenthood Federation of Canada, "Eighty-three percent of Canadian adults believe that sexuality education should be taught in the schools."[13] A majority of parents do, in fact, want their children to receive sexuality education in the public school system, either as a supplement to or substitute for education by parents in the home. Those parents who object to such education are in the minority. Children and teens need reliable and comprehensive sexuality information, in the same way that they need information on current affairs and future job prospects, if they are to grow into responsible adults making informed choices.

It is clear that any sexuality education program or service designed to reduce teenage pregnancy and STD infection rates must target parents as well as children and teens. Many parents who want to provide sexuality information for their children at home could benefit from participating in structured or informal discussion groups or peer counselling sessions which would reduce their discomfort with the topic and provide them with up-to-date information.

EXISTING SEXUALITY EDUCATION PROGRAMS IN NOVA SCOTIA

Planned Parenthood Nova Scotia and Affiliates[14]

Planned Parenthood of Nova Scotia and its five regional affiliate offices

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[11] Gallup Canada, Survey of Canadian Schools.

[12] Canada Youth and AIDS Study, Nova Scotia Report, p. 19.

[13] Planned Parenthood Association of Nova Scotia, "Five Ways to Prevent Abortion".

[14] Correspondence and materials, Planned Parenthood Nova Scotia.

provide information and services concerning family planning methods and sexually transmitted diseases. Affiliate offices are located in Amherst, Sydney, New Glasgow, Halifax and Bridgewater. While all the affiliates provide education and resource services, Metro Area Family Planning in Halifax is the only office equipped and funded to provide a clinic service. Contraceptive prescriptions or fittings, pregnancy tests, and STD diagnosis and treatment are among the services offered.

Over 9,000 people made use of the Metro Area Family Planning clinic, educational, and resource services in 1988. The vast majority of the 3,210 clinic users reside in Halifax (70 percent) or Dartmouth (17 percent); 60 percent of the clinic users were high school and university students.[15] Clearly, there is a great demand for this service in the metro area, particularly by teenagers who are unwilling to consult their parents' family doctor about sexual health and reproductive concerns, and by young adults who often do not have a family doctor while they are attending university in Halifax. This raises concerns about students at universities, community colleges, and vocational schools in other areas of the province who do not have access to such vital clinic services.

Personal Development and Relationships and Home Economics, Department of Education[16]

A "Personal Relationships and Development" (PDR) course for grades 7, 8, and 9 has recently been implemented in junior high schools throughout Nova Scotia. The five components of the courses include Career Planning, Feelings, Human Growth and Development, Relationships, and Self. The Human Growth and Development component provides information on conception (grades 7 and 8) and teenage pregnancy (grade 9), and sexually transmitted diseases, including AIDS (grades 7, 8 and 9). The exact nature of this information, and the amount of time spent covering any particular topic, is to some extent dependent on the individual teacher. An extension of this course at the high school level is

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[15] Correspondence and materials, Metro Area Family Planning.

[16] Correspondence and materials, Kaye MacKinnon, Home Economics/Health Consultant, Department of Education.

presently being developed.

In addition, a "Child Studies" (Home Economics) course is offered at the grade 11 level and provides students with information concerning human reproduction, family planning and pregnancy. This course is offered as an elective, however, and young women are still the overwhelming majority in "Child Studies" classrooms. Significantly, another elective course, "Canadian Families", offered at the grade 12 level, does not include any information on reproductive decision-making in a family context.

Community Health Nursing, Department of Health and Fitness[17]

In 1988, a Sexuality Education Program was initiated by the Community Health Nursing Division of the Department of Health and Fitness. Each of the seven Health Units across the province has designated two Sexuality Education Resource Nurses (SERNs) who provide sexuality education to the public in addition to their other activities. No direct clinical services are available. SERNs have only received a total of four days of special training sessions since the inception of this program. Other than this limited training, the community health nurses designated as SERNS do not necessarily have any special expertise, interest, or comfort in dealing with sexuality issues. While the attempt by already-overworked community health nurses to provide family planning services is admirable, they cannot possibly meet the growing need and demand for information. As an Advisory Council fieldworker reported, "The nurses I spoke to... mentioned that due to staff shortages they were unable to give much attention to Health Education and [they] felt there was a great deal more that could be done with more staff."[18]

The department has a part-time (eight hours per week, weekday evenings and Saturday mornings) family planning nurse who serves Hants, Annapolis and Kings counties. She provides counselling services, and birth control and STD information. She conducts workshops on these subjects in schools and to

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[17] Correspondence and materials, Heather Young, Assistant Director, Community Health Nursing, Department of Health and Fitness.

[18] Jennifer Rennison, Advisory Council on the Status of Women Field Work Report.

community groups upon request. As well, the nurse has a telephone hotline where teens can call for information and counselling. While the phone line was initially set up to handle adolescents' concerns, many parents also call seeking information and guidance. The main topics of concern are sexually transmitted diseases (including AIDS), birth control, sexuality, and pregnancy. The phone line is on the Kentville exchange and is not toll-free. Teens from out of the catchment area are able to call collect, however very few do. Since its inception in 1981, the family planning nurse has received a total of 578 calls, including 118 requests for programs or talks to groups.[19] Once again, the success of this very limited service in the Valley emphasizes its absence in other areas.

Family and Children's Services, Department of Community Services[20]

Family and Children's Services deals with teenagers and single parents, among others, and individual workers may deal with family planning issues to a limited degree if a client seeks or is perceived to need such information. No formal family planning programs are offered through this department and generally clients are referred to doctors or public health nurses regarding sexuality, birth control, and sexually transmitted diseases.

Psychiatric Mental Health Services, Department of Health and Fitness[21]

As with Family and Children's Services, no formal family planning services are available and clients are referred elsewhere for information and services.

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[19] Correspondence and materials, Phyllis Sweet, Family Planning Nurse, Kentville.

[20] Correspondence and materials, Rosemary Rippon, Director, Family and Children's Services, Department of Community Services.

[21] Conversation, Susan Pirie, Social Work Consultant, Department of Health and Fitness.

University Health Centre and Counselling Services[22]

While clients at university counselling centres present mainly academic and career concerns, many students also seek help with personal concerns, which may include sexual issues. A sexual issue, in its broadest context, may include pregnancy, AIDS and other STDs, sexual identity, gender issues, dating, value conflicts, peer pressure, date rape, rape, and adult survivors of childhood sexual assault. Often, students' sexual concerns are one element of a complex problem, making it difficult for counsellors to estimate the demand for this part of their service.

Universities which have resident health nurses and physicians, or health centres on campus, are most often referred those students who request sexual health information or counselling. Sandra Cook, a nurse at the Mount St. Vincent University Health Office, estimates that 50 percent of the 2,500 students her office sees each year come for sexual health reasons. Many students come to the centre with "vague notions" and "a lot of myths" about sex, STDs, and birth control.

Most campuses offer evening workshops and sessions for students living in residence on a variety of sexual issues. Universities in the Metro area make use of the services of the Metro Area Family Planning Clinic and Acadia University makes use of the Family Planning Nurse in Kentville as an additional resource.

Inequity in Access

Forty-six percent of Canadians feel they do not have access to contraception and family planning services[23], yet 96 percent of young people aged 15 to 24 believe that birth control information should be available to those who

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[22] Conversations with counselling centre and health centre staff at Acadia, Dalhousie, Mount St. Vincent, St. Mary's, and St. Francis Xavier Universities.

[23] Planned Parenthood Federation of Canada

want it.[24] As we have seen, access to family planning programs and sexuality education is severely constrained in this province. Only 33 percent of Atlantic Canadians are satisfied with the level of family planning services.[25] Table 1 provides a visual illustration of those geographic areas served by the programs and services offered by the agencies listed above. It is clear that counties having limited or no family planning programs and/or services are in the majority.

Financial and educational barriers compound the geographical access problem for low-income individuals. The Advisory Council's fieldworker on the Eastern Shore reported that area women can "obtain birth control pills at Planned Parenthood at a reduced cost if they can get to Planned Parenthood in Metro. Transportation remains a problem for disadvantaged adults and for students. Information is available if you know what information you want and who to go for it. If you don't, then libraries full of it are of no consequence."[26]

Geographical isolation and limited economic resources are not the only barriers that confront individuals attempting access health care. Culturally sensitive material must be provided for a variety of ethnic groups whose members may have different expectations for sexual behaviour or may face language or other barriers which prohibit them from understanding educational materials or programs.

In Ontario it is estimated that as many as 89 percent of adolescents have geographic access to clinic contraception services. Researchers conclude that "it is the contraception clinic services which currently cut across locality SES [socio-economic status] and better enable adolescents to avoid unwanted pregnancy no matter where they live in the province".[27] The government of Nova Scotia must recognize the importance of family planning clinic services as the cornerstone of a preventative approach to sexual health, and take immediate steps to increase

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[24] Planned Parenthood Federation of Canada, Directions for a Sexual and Reproductive Health Policy for Canada, p. iii

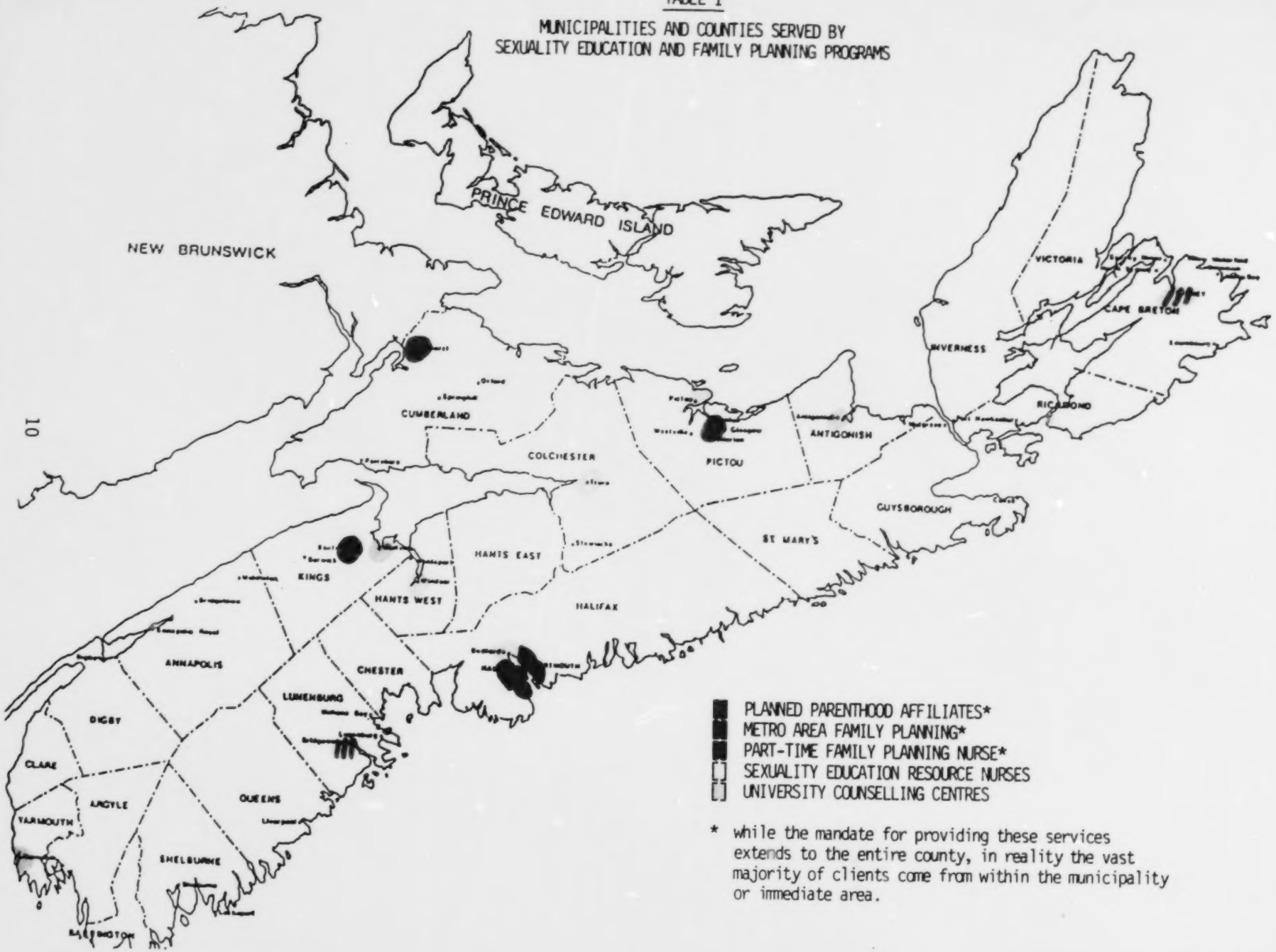
[25] "Gallup Poll reveals attitudes toward sexuality", p. 25-27.

[26] Robinson, NSACSW fieldworkers report, p. 3. Emphasis in the original.

[27] Orton and Rosenblatt, Executive Summary, Adolescent Pregnancy in Ontario: Progress in Prevention, p. 3 & 7.

TABLE 1

MUNICIPALITIES AND COUNTIES SERVED BY
SEXUALITY EDUCATION AND FAMILY PLANNING PROGRAMS



* while the mandate for providing these services extends to the entire county, in reality the vast majority of clients come from within the municipality or immediate area.

the number of such clinics in this province to ensure better access for all Nova Scotians.

"Divine Immunity"

As we have seen from the above discussion of existing services, most of the dissemination of sexuality education occurs as a result of a client's request, with the exception of the PDR program in the schools. Guidance counsellors, public health nurses, social workers, and others generally receive requests for information after the fact -- when the client is already pregnant or suspects they have already contracted a sexually transmitted disease. What this means is that teenagers and adults do not actively seek vital information about birth control and safe sex practices until it is too late. Clearly, many people never seek such information for a variety of reasons. For some, talking about sex remains difficult and embarrassing. Others do not recognize that sexuality information is a necessary element of overall health self-care. They simply do not realize that they are at risk.

An Eastern Shore guidance counsellor reported that students from the area never ask her for information on sexually transmitted diseases, because "most kids believe they have a "Divine Immunity" and simply have no fear of it at all". Another guidance counsellor form the same area stated that "no student has ever come to her looking for birth control, they come when they think they might be pregnant."[28] This "It won't happen to me" attitude which typifies many teenagers has been well documented.[29] More education is necessary to demonstrate that pregnancy, infertility or permanent sterility, disease and even death can occur in all age groups as a result of unprotected sexual activity.

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[28] Robinson, NSACSW fieldworkers report, p. 2

[29] Planned Parenthood Federation of Canada.

THE PUBLIC AND PRIVATE COSTS OF UNPLANNED PREGNANCIES

Public Costs

What does the lack of adequate family planning actually cost the Province of Nova Scotia? Table 2 has been modified from a 1984 study prepared by the Planned Parenthood Association of Nova Scotia.[30] Only the costs of teenage pregnancies have been included in the table rather than the costs of all pregnancies to unmarried mothers. The Advisory Council feels that to assume that all unmarried mothers are the victims of accidental pregnancies, and that all married mothers plan their children, does a gross disservice to both single and partnered adult women and hides the realities of some single and lesbian women who choose to have children and of the many married women who experience unplanned pregnancies. We do feel, however, that we can safely assume that the vast majority of teen women who get pregnant did not intend to do so when they engaged in sexual activity.

According to the evaluators of an adolescent pregnancy prevention program in Ontario, "The cost/benefit argument for prevention is irrefutable. Due to the declining rate since 1975 [the year the program was initiated], we have avoided 21,633 pregnancies to adolescents by 1983 -- similar to the number we actually did have in 1975. We estimate $41.4 million would have been spent on abortions, births, general welfare and family benefit payments (for one year only) to adolescent sole-support mothers, for that number of pregnancies. During that period, public health family planning services spent $16.4 million for adolescent clients." Since there is a direct relationship between the implementation of the adolescent pregnancy prevention program and the declining birth rate, the Ontario government saved $25 million on the short-term consequences of adolescent pregnancy. The researchers concluded that the Ministries of Education, Health, and Community Services "could establish a budget specifically for prevention of adolescent pregnancy and still save money."[31] The Planned

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[30] Planned Parenthood Nova Scotia.

[31] Orton and Rosenblatt, Executive Summary, Adolescent Pregnancy in Ontario, p. 8. Emphasis in the original.

Parenthood Federation of Canada estimates that each dollar spent on the prevention of adolescent pregnancy can save more than $6 in future medical and social service expenditures.[32]

TABLE 2

Monetary Costs Related to Lack of Family Planning Services Nova Scotia, 1983-84[33]

Therapeutic abortions performed in Nova Scotia	$ 621,551
Live births to teenage mothers	4,029,281
Family benefits to teenage mothers	748,800
Foster/temporary care to children of unmarried mothers[34]	818,806
Public Health postnatal visits to 1,299 teen mothers	135,096
TOTAL	$6,353,534

[32] Planned Parenthood Federation of Canada Request for Funds, 1982-83, Submitted to the Federal Department of Health and Welfare.

[33] Costs that are not incorporated into this table include social services related to unplanned pregnancies (e.g., caseworker salaries), daycare programs in high schools, Bethany Home operating costs, Home of the Guardian Angel operating costs, indirect health service costs (e.g., home visits), as well as many other more "hidden" costs, such as those absorbed by the families of financially-dependant pregnant teens. Also, since we feel unable to make the assumption that all unmarried women are unwilling mothers, and vice-versa, the costs that are included in this table represent a minimum expenditure and are in most cases greatly underestimated. It has been suggested that as many as half of all conceptions, including those occurring within marriage, are unplanned. See for example, Day 1988, Genevie and Margolies 1987, and Ory 1978, among others.

[34] Expenditures for "teenage mothers" and "unmarried mothers" could not be separated in this category.

Private Costs

The private costs of unplanned pregnancy, whether terminated or continued, are tremendous. Women who choose to have abortions or to surrender their infants for adoption at birth usually do so only after much deliberation and pain. These are never easy choices and are always accompanied by some disruption in the woman's life, involving time, health risks, and often personal finances. A woman unable to obtain an abortion at her local regional hospital must travel to the Victoria General Hosptial in Halifax at her own expense, or even to Montreal or New England at an average cost of $1,500.[35] In 1988, 47 Nova Scotian women travelled to the Montreal Morgentaler Clinic to obtain abortions[36], at a total cost of approximately $70,000. The number of women who travelled to clinics elsewhere in Canada and the United States is unknown.

Women who continue with unplanned pregnancies face life changes that cannot be measured. Women's whole lives, their educational and career plans, and their relationships with their parents, partners, and other children (if they have any) may be seriously affected.

The Public and Private Costs of Sexually Transmitted Diseases

The costs of treating sexually transmitted diseases and pelvic inflammatory disease are very significant. In Canada, hospital admissions for pelvic inflammatory disease (PID) have more than doubled during the past 15 years.[37] Treatment of PID in Nova Scotia cost the province $24 million in 1983/84. The management of STDs is a clear indication of the lack of emphasis placed on prevention by our health care system. The incidence and complications arising from STDs could be greatly reduced through effective education about the diseases and their modes of transmission. A recent statement by a representative of the Canadian Public Health Association estimated that each new AIDS patient

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[35] Communication, Halifax Morgentaler Clinic.

[36] Communication, Halifax Morgentaler Clinic

[37] Departmental Task Force on Reproductive Health, Reproductive Health Activities and Concern, p. 71

costs the Canadian health care system $70-100,000 a year.[38]

The National Consultation on Research Needs in Sexuality and Reproductive Health urgently recommended "that government agencies provide adequate resources to better manage sexually transmitted diseases (STDs) in all aspects...so that ultimately the costs that are being incurred to manage pelvic inflammatory disease and its complications can be reduced. For example, $132 million (1981-1982) were spent in the direct and indirect costs of managing PID and ectopic pregnancy in Canada".[39]

We are concerned about the financial resources being devoted to the research and practice of new reproductive technologies. When this is measured against the funds devoted to the prevention of STDs and pelvic inflammatory disease, which are major causes of infertility, we see prevention dollars forsaken for expensive medical intervention.

Private Costs

As with unintended pregnancies, the private costs of STDs are immeasurable. Such costs may include loss of time from work or leisure activities, inability to engage in healthy and safe sexual activity (either temporarily or permanently), pain and discomfort, infertility or sterility, and even death. In particular, the cost of infertility has been well documented in light of the current media coverage of new reproductive technologies. "There is considerable evidence that lifestyle patterns and sexually transmitted diseases are causing an increased burden of infertility. The magnitude of infertility is not known."[40] Women who are infertile and/or who undergo invasive diagnostic procedures for infertility

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[38] "Spiralling cost of AIDS care called impetus for education", The Globe and Mail.

[39] Calgary Health Services, Report of the National Consultation on Research Needs in Sexuality and Reproductive Health: A Public Health Perspective, p. 22

[40] Calgary Health Services, Report of the National Consultation on Research Needs in Sexuality and Reproductive Health: A Public Health Perspective, p. 8

can attest to the physical and emotional suffering they experience.[41]

Dual Protection

The concept of "dual protection"is an important one in sexuality education.[42] Those who engage in unprotected sexual activity face two serious risks -- unintended pregnancy and sexually transmitted disease. Generally speaking, "safe sex" practices are measures that serve to lessen the risk of both undesirable possible outcomes. What this means in concrete terms is that both risks can be lowered by the same educational programs. We strongly recommend that any program that is implemented recognize the concept of dual protection in order to provide Nova Scotians with both contraceptive and STD information, regardless of the "presenting problem." In other words, women undergoing therapeutic abortions or individuals seeking birth control should receive relevant and sensitive information and counselling about sexually transmitted diseases as well as contraceptives; individuals seeking treatment for a sexually transmitted disease should also receive information about avoiding unwanted pregnancy.

The Advisory Council on the Status of Women believes that the comprehensive implementation of family planning services and the development of safe, effective and accessible contraception will reduce the need for abortion services, cut health care costs and decrease the incidence of sexually transmitted diseases. We urge the government to consider carefully the monetary, health, and psychological costs of failing to provide preventative sexuality information to the people of Nova Scotia.

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[41] Klein, Infertility: Women Speak Out about their Experiences of Reproductive Medicine.

[42] In 1988, the Sexuality Division and Health Education Division of Calgary Health Services produced four public service announcements designed to promote the concept of dual protection. The PSAs were aimed at young adults aged 20 to 29, the group at highest risk for sexually transmitted disease and a large number of unwanted pregnancies.

Recommendations

The Nova Scotia Advisory Council on the Status of Women recommends:

1) that the Province of Nova Scotia recognize the importance of sex education in (a) the prevention of unintended pregnancy, and (b) the prevention of all sexually transmitted diseases, including AIDS;

2) that the Province of Nova Scotia increase funding to expand family planning programs, sex education, and pre- and post-abortion counselling in this province in an effort to reduce the number of unintended and unwanted pregnancies;

3) that the Province initiate much-needed professional research and evaluation to determine in greater depth the extent and effectiveness of family planning programs in Nova Scotia;

4) that the Province recognize the importance of family planning clinic services as the cornerstone of a preventative approach to sexual health, and take immediate steps to increase the number of such clinics in this province to ensure better access for all Nova Scotians;

5) that the Province provide funding for information services that are specifically geared to adolescents and their parents, both in terms of content and medium;

6) that the Province recognize the importance of culturally relevant and sensitive sexuality information and education for Nova Scotia's major ethnic groups, and provide funding to organizations such as MISA (Metropolitan Immigrant Settlement Association) and MANS (Multi-Cultural Association of Nova Scotia) for sexuality education. Other "special-needs" groups and individuals, such as those developmentally or physically handicapped, must not be overlooked;

7) that any program that is implemented recognize the importance of the concept of dual protection in order to provide Nova Scotians with both contraceptive and STD information, regardless of the "presenting problem";

8) that the Department of Education recognize that leadership on this issue is vital, and work towards the education of teachers, principals, school administrators, and board members in recognition of the high rates of sexual activity among teenagers in Nova Scotia, and the acceptance of extended family planning and sexuality education programs to combat the unintended results of this sexual activity; and

9) that the Department of Community Services expand its mandate to provide family planning and sexuality education programs for clients, both teens and adults.

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